UK NR 5/19/06 admin notified 7/6/06 B. Carson

PRINTED: 05/10/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare Recertification survey conducted in your facility from 4/24/06 through 4/28/06. The census at the time of the survey was 115. The sample size was 25. Two complaints were investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. Complaint #NV00011337 was a self-reported incident of two residents involved in an altercation. The incident did occur with no regulatory deficiencies cited. Complaint #NV00010832 was a self-reported incident of alleged misappropriation of resident property. The complaint was unsubstantiated.	F 000	**F00** **This plan of correction is prepared And executed because it is required by The provisions of the state and federal regulations and not because Hearthstone agrees with the allegations and citations listed on this statement of deficiencies. Hearthstone maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Hearthstone's credible allegation of compliance.** **By submitting this plan of correction, Hearthstone does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Hearthstone reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.**	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Molly A. Larson — TITLE: Administrator — (X6) DATE: 5/18/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.	F 156	**F 156** **All residents have the potential to be affected by this deficient practice.** **Residents # 1,2,10,11,12,13,24 &25 will be provided with all information necessary to make informed decisions regarding Advanced Directives.** **Social Services, Admission Coordinator, and Nursing will be in serviced on necessity of providing Advanced Directives information to all residents admitted and to receive signed acknowledgement.** **Social Services/Nursing will be responsible for presenting Advanced Directive information to all new admissions and ensuring signed acknowledgements are received and in the chart.** **Director of Education will arrange for Community Education on the subject of Advanced Directives, Durable powers of attorney for health care, the right to accept or refuse medical and or surgical treatment and information detailing the facility's internal policies and procedures with regard to those resident rights.** **This corrective action will be monitored in the Standards of Care meeting weekly x 90 days to ensure it will not recur.**	6-8-06

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F 156	Continued From page 2 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews it was determined that the facility failed for 8 of 25 residents to ensure that upon each and every admission to the facility, residents were provided with all of the information necessary to make informed decisions regarding the right to formulate advanced directives (Residents #1, #2, #10, #11, #12, #13, #24, and #25). In addition the facility failed to provide community education on the subject of advanced directives, durable powers of attorney for health care, the right to accept or refuse medical and or surgical treatment and information detailing the facility's internal policies and procedures with regard to those resident rights. Findings include: Resident #1: This 79 year old female resident was last admitted to the facility on 3/14/06, with diagnoses that included paralysis, chronic obstructive pulmonary disease, dementia with behavior disturbances, status post hip fracture, hypothyroidism, osteoarthrosis and congestive heart failure. A review of Resident #1's record and the facility's Resuscitation Designation document revealed that the legal representative signed it on 3/17/06. The document indicated that the resident did not want cardiopulmonary resuscitation to be performed at the facility if the resident was to suffer a cardiac or respiratory arrest. Further review of the records revealed that there was no evidence that Resident #1 was provided with all of	F 156		

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F 156	Continued From page 4 the advanced directive information that is customarily given by the staff member who was responsible for admissions coordination. Interviews with staff revealed that staff member responsible for ensuring that upon each and every admission all residents were provided with the advanced directives information was also responsible for making sure that the Resuscitation Designations form was signed. Staff interviews also revealed that there was a four part copy form that is used and that the pink copy was to be kept in all residents records at all times. The pink copy was not available in Resident #1's medical record and there was no indication that the four part form was ever reviewed and signed by a responsible party. Resident #2: This 81 year old female resident was admitted to the facility on 10/25/05, with diagnoses that included peripheral vascular disease, chronic obstructive pulmonary disease, malignant cancer of the breast, leg varicosity ulcers, cellulitis, aortic valve disorder. A review of Resident #2's medical record revealed that at the time of admission there was no acknowledgment of advanced directives in the resident's record. Interviews with staff revealed that the form was not located in any of the designated places i.e., social services office and or in the admissions office. Interviews with social services staff and administrative staff revealed that during the past year the facility did not provide the surrounding community with education on the subject of advanced directives and what the facilities internal policies were.	F 156		

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F 156	Continued From page 5 Resident #12: The resident's current admission date was noted as 4/4/04. The diagnoses included hypertension, Alzheimer's disease, esophageal reflux, aortic valve disorder, hypothyroidism, and depression. A review of the record revealed a durable power of attorney for health care decisions dated, 6/19/00. A review of the active residence record failed to find an acknowledgment of advanced directives for the admission of 4/4/04. Resident #13: The resident's current admission date was noted as 12/09/05. The diagnoses included congestive heart failure, anemia, and depressive disorder. A review of the active record failed to reveal an acknowledgement of advance directives. The resident also stated that she did not receive information regarding advance directives. Resident #24: The resident's current admission date was noted as 1/05/06. The diagnoses included anemia, hypertension, and diabetes. A review of the active record failed to reveal an acknowledgement of advance directives form. Resident #25: The resident's current admission date was noted as 10/20/03. The diagnoses included vascular dementia, hypothyroidism, and depressive disorder. A review of the active record failed to reveal an acknowledgement of advance directives form. Resident #10: The resident was admitted to the facility with diagnoses including digestive-genital fistula, cardiovascular disease, obstructive hydrocephalus, and depression. A review of the record failed to reveal a current acknowledgement of advanced directives form.	F 156		

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F 157	Continued From page 7 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to report a significant mental change of condition to the physician in a timely manner for 1 of 25 residents. (Resident #16) Findings include: Resident # 16: The resident was re-admitted to the facility on 4/16/06 with diagnoses including bi-polar disorder, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and dementia. On 4/25/06 at approximately 2:15 PM the resident was observed by a surveyor in the director of nurses's (DON) office being very angry and threatening the DON with bodily harm. The resident did not explain why she was angry. Finally staff were able to redirect and calm the resident. An interview with the charge nurse revealed that earlier in the day a staff member went into the resident's room and asked if she could photograph her for her record. The resident got extremely upset and refused to have her photo made. The resident accused the staff of trying to feed her to the Africans. A review of the resident's record revealed that the	F 157		

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F 156	Continued From page 6 Resident #11: The resident was admitted to the facility on 12/1/03 with diagnoses including acute ill defined cardio-vascular disease, depressive disorder, hypokalemia, abdominal aortic aneurysm, hemiplegia, ischemic heart disease, and protein-calorie malnutrition. A review of the record did not reveal evidence of an acknowledgement of advanced directives form from the most recent admission.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F157** **All residents have the potential to be affected by this deficient practice.** **Resident #16 was seen by Physician on 4/25/06 and a medication change was made for Depakote Sprinkles. After resident continued to refuse medication a psychiatric consult was done and resident transferred to a psychiatric facility, where she remains.** **Nursing staff will be in serviced by DON/ADON on the necessity of notifying the physician on changes in residents behaviors/conditions or refusal of medications in a timely manner and that all refusals of medication will be reflected on the 24 hour report.** **DON/ADON/ will monitor on a daily basis by review of the 24-hour report.**	6-8-06

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F 157	Continued From page 8 resident had been behaving strangely for a few days and making bizarre statements. It was also revealed that the resident had been refusing to take her Depakote for six days. The Resident was prescribed Depakote 500 milligrams twice per day. The medication administration sheet revealed the resident had refused 11 doses. The charge nurse indicated she had written a note to herself to notify the physician, but had not done so. The record also noted that the resident was refusing to use her oxygen as ordered. A review of the monthly behavior monitoring sheet revealed that the resident had four episodes of agitation on 4/22/06, and three episodes of yelling at staff on 4/22/06. There were four episodes of delusional statements on 4/25/06 and one episode on 4/24/06. The facility called the physician on 4/25/06 after the surveyor notified the charge nurse that the physician was in the building. The physician changed the resident's medication order to Depakote sprinkles 500 milligrams twice per day. The record revealed that the resident refused the medication at 6:30 PM on 4/25/06. The physician also ordered a referral for psychiatric evaluation. The resident was transferred to a psychiatric facility on 4/26/06. The facility failed to notify the physician when the resident refused her medications and began to exhibit behaviors.	F 157		
F 164 SS=B	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical	F 164		

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F 164	Continued From page 9 records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, it was revealed that the facility failed to guard the confidentiality of the clinical records for 1 of 2 wings of the facility. Findings include: The facility had two wings, A and B. Each wing consisted of 3 pods with a central gathering area. On B-wing the charts were stored in the central	F 164	**F 164** **All residents have the potential to be affected from this deficient practice.** **Chart racks on all pods have been secured.** **Licensed staff will be in serviced by the director of Education on privacy and confidentiality rules and regulations.** **DON/designee will complete daily rounds to assure compliance with chart racks being secured.**	6-8-06

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F 164	Continued From page 10 area in covered and locking chart racks on each pod. On 04/24/06 and at random times during the course of the survey, the chart racks were observed to be open, unlocked, and unattended in the pods on the B wing of the facility.	F 164		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident interview it was determined that the facility failed to care for the resident in a manner that maintained the resident's dignity for one non-sampled resident. (Resident #A) Findings include: Resident A: This resident was a non-sampled resident that was interviewed during the group interview. The group interview was held on 4/25/06, at 2:30 PM. The resident was alert and oriented. He spoke in a manner that was clear and understandable. The resident stated that he was awakened during the night to have his photo taken. He gestured with his face and hands the half asleep, surprised look he had when his photo was taken. He stated that the photo was taken of him in bed in his pajamas.	F 241	**F241** **A new photo has been taken of resident A during the daytime and in clothing of his choice.** **All residents have the potential to be affected by this deficient practice.** **Education Director will provide in service training to staff on Dignity.** **We will monitor in the Standard of care meeting and by Quality Assurance.**	6-8-06
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 11 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to update the care plans for 3 of 25 residents to reflect changes wound in care. (Residents #23, #20, and # 18) Findings include: Resident #23: The resident was admitted to the facility on 4/11/06 from an acute care facility. Admission orders received by the facility included wound care to be performed on lateral and medial calf wounds of the resident's left leg. The orders were to clean both wounds with wound cleaner and to pat dry. Staff were then to apply an oil emulsion gauze to the wound bases, to pack with	F 279	**F 279** **All residents have the potential to be affected by this deficient practice.** **Resident #23 has been discharged from facility. Resident # 20 has been discharged from the facility. Resident # 18 has a comprehensive care plan for wound care at this time.** **In service will be provided to Licensed Staff by Director of Education/DON relating to care planning physician orders and change in residents care.** **Monitoring will be completed in the Standards of Care meeting weekly x 90 days.**	6-8-06

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F 279	Continued From page 12 normal saline solution soaked gauze, and to secure with a clear drape. A wound vacuum drainage system was to be used on both wounds. This drainage system was to be set at 125 mm (millimeter) negative pressure. The resident was to receive wound dressing changes on Monday, Wednesday and Friday. Resident #23 was also to have wound care performed to a Stage I pressure ulcer of the left heel. This wound care included cleaning with wound cleaner, to pat dry, to apply skin prep, and to leave open to the air. A heel lift boot was to be applied to Resident #23's left heel whenever he was in bed. Record review of the care plans for Resident #23 revealed that the facility had developed care plans for the following: pain control, injury secondary to falls, pressure ulcers, and nutritional needs related to the left leg wounds. There were no care plans that addressed wound assessment, wound care treatment or the wound vacuum drainage system present in the clinical record. Interviews on 4/28/06 with the wound care nurse as well as the nurse assigned to that wing confirmed that there were no care plans concerning the wound care or wound vacuum drainage system management found in the clinical record. Resident #20: The resident was admitted to the facility on 3/27/06 from an acute care facility for wound care of a foot injury. Several toes of the resident's left foot had been amputated. An admission intake form of the facility indicated that the resident had a wound vacuum drainage system that needed to be ordered. This entry was dated 3/27/06.	F 279		

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F 279	Continued From page 13 Record review revealed that Resident #20 had wound care performed on Monday, Wednesday, and Friday. This care involved cleaning the resident's wounds with wound cleaner and to pat dry. Staff then applied oil emulsion to the wound, applied a black wound vac sponge to the wound, applied a drape, and applied a wound vacuum drainage system at 125 mm suction (negative) pressure. Record review of the care plans revealed that the facility developed care plans for the following: control of pain, injury secondary to falls, pressure ulcers, dependency for ADL's (Activities of Daily Living) and nutritional needs related to diabetes and/or pressure ulcers of the resident's leg and foot. There were no care plans that addressed wound assessment, wound care treatment or the wound vacuum drainage system present in the clinical record. Interviews on 4/28/06 with the wound care nurse as well as the nurse assigned to that wing confirmed that there was no care plan present in the chart for Resident #20 related to the wound care. Resident #18: The resident was admitted to the facility on 12/1/05. After admission, the developed a wound to the outside of the foot after wearing poor fitting shoes brought in by a caregiver. The facility initiated wound care on 2/26/06. The wound care order included cleaning the left lateral edge of the foot daily with wound cleaner, to pat dry, to apply skin prep, and to cover with optifoam until healed. On 3/2/06 an antibiotic was ordered (Keflex) treat cellulitis of the left foot. The wound care was changed to use normal saline instead of wound cleaner to	F 279		

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F 279	Continued From page 14 cleanse the wound. On 4/18/06, the physician ordered a podiatry consult and an x-ray of the resident's left foot to rule out osteomyelitis. Levaquin, an antibiotic, was ordered for 14 days. On 4/24/06 the wound care ordered was changed to cleaning the wound with normal saline and leaving the wound open to the air. Review of the record revealed that the care plan was developed on 12/14/05 following a comprehensive evaluation. Concerns identified did include identifying Resident #18 to be at risk for falls and pain, but the care plan was was not updated to reflect the altered needs related to the wound on the left foot. Record review also revealed that the care plan was updated on 4/18/06 which identified the risk of complications related to cellulitis and included the addition of Levaquin medication therapy, the x-ray, and the podiatry consult, however, there was no care plan dedicated to the wound care treatments. An interview with the charge nurse for the wing confirmed that there was no care plan for Resident #18 related to the wound treatment. An interview on 4/28/06 at 8:15 AM with the wound care nurse revealed that any staff member could add to the resident care plan. The wound care nurse also stated that the night shift nurse was to check the charts for new orders and could update the care plans at that time. The wound care nurse also confirmed that she tried to update the care plans when wound care changes occurred.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	F 281		

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F 281	Continued From page 15 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to accurately document the administration of tube feedings and to document an assessment of tube placement that met the professional standards of quality for 1 of 25 residents. (Resident #14) Findings include: Under NAC 632.212, in the Nevada State Board of Nursing Nurse Practice Act, "A registered nurse shall demonstrate in the performance of those duties, competence in: (i) Administering medication and carrying out treatments which are properly authorized." The facility's Nursing Standards of Practice, subject: enteral feeding - general information for writing tube feeding orders, page NP-E-15, reveals "Document the amount of formula and water provided every eight (8) hours. Total intake every twenty-four (24) hours. Check tube placement before initiation of formula, medication administration, and flushing tube or at least every eight (8) hours. Check and record residuals every shift." None of the notes that were reviewed contained the information as quoted from the facility practice manual. Resident #14: This resident was admitted to the facility on 03/27/06 with gastrostomy (G-tube) feedings and a colostomy. The initial orders for	F 281	**F 281** **Resident # 14 has been discharged from the Facility.** **All resident have the potential to be affected by this deficient practice.** **In service will be provided to all nursing staff on the proper documentation and Standards of Practice for g-tubes by ADON/designee.** **Telephone orders change in g-tube feeding will be monitored daily by DON/designee and random audits will be completed for proper documentation.** **DON/ADON/Quality Assurance will monitor.**	6-8-06

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F 281	Continued From page 16 this resident was for continuous tube feedings at 60 cc per hour for the entire 24 hours in each day. This order was changed on 03/30/06 to 70 cc per hour continuous with a break in the schedule for the feeding to be stopped from 8:00 AM to 10:00 AM and from 4:00 PM to 6:00 PM. The record failed to reveal that the tube feeding was stopped at 4:00 PM and restarted at 6:00 PM for the dates of 04/02/06 through 04/22/06. There was documentation for disconnect at 8:00 AM and reconnect 10:00 AM on 04/01/06, 04/06/06, 04/11/06, 04/13/06-4/15/06 and 04/19/06-04/22/06. The rest of the dates for time period 04/02/06 through 04/22/06, contained no documentation for the morning disconnect and reconnect. The nurse's note of 04/14/06 documented a flow rate of 50 cc per hour with no corresponding physician order to change the rate from 70 cc to 50 cc per hour. There was no documentation in any of the nurses' notes that indicated the placement of G-tube was assessed in accordance with the facility's policy.	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that 1	F 309		

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F 309	Continued From page 17 of 25 residents received necessary services to treat depression and maintain the highest level of physical and psycho-social functioning. (Resident #11) Findings include: Resident #11: The resident was admitted to the facility on 12/1/03 with diagnoses including acute ill defined cardio-vascular disease, depressive disorder, hypotassemia, abdominal aortic aneurysm, hemiplegia, ischemic heart disease, and protein-calorie malnutrition. The resident had shown symptoms of depression since admission. According to the record the resident refused to leave her room, spent most of the time in bed, refused to participate in any group activities, or dining outside her room. The resident's privacy curtain was pulled around her bed and she remained in her room during the entire survey. According to the medical record the resident received a psychiatric evaluation on 12/24/03. At that time the resident was placed on Remeron for depression. The resident took the medication for 13 months and then refused to take the medication any longer, stating that she "did not like the way it makes me feel." No other psychiatric consultations were done. The resident entered the facility weighing 107 pounds. The ideal body weight was listed at 115 to 121 pounds. The resident had experienced a steady weight loss over the last 180 days. The resident's weight on 4/25/06 was 93 pounds. According to the meal record for March 2006 the resident refused twelve meals during the month.	F 309	**F 309** **All residents have the potential to be affected by this deficient practice.** **Psychiatric consultation has been ordered for resident #11. Nutritional assessment has been completed due to weight loss.** **Housewide audit of all residents with a diagnosis of depression will be completed to ensure that they get an annual psychiatric evaluation as needed. The weight committee meeting will continue to evaluate weight changes and implement appropriate interventions.** **Residents with Diagnosis of Depression and their treatment will be monitored in Standard of Care meetings.** **The Weight Committee will monitor residents with weight fluctuations in weekly weight meetings.**	6-8-06

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F 309	Continued From page 18 According to dietary progress notes the resident's average percentage intake was 15-25% at breakfast, 38% at lunch, and 40% at dinner with refusals less than 50%. According to the social worker, the resident preferred not to socialize even with encouragement, and sometimes refused all or most of her medications. She also sometimes had outbursts of anger toward the staff. The facility failed to take aggressive action to prevent significant weight loss and to increase the resident's psycho-social functioning.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review it was determined that the facility failed to provide the necessary pressure relieving measures to promote the healing of a pressure sore for 1 of 25 residents. (Resident #24) Findings include: Resident #24: The resident's current admission	F 314	**F 314** **All residents have the potential to be affected by this deficient practice.** **A new turning and repositioning schedule was initiated for resident #24. New interventions have been put into place and changes in treatments have been implemented.** 6-8-06 **Two-hour turning and repositioning record for this resident will be kept in Medication Administration Record to be initiated and completed by Nursing Staff. Non healing wounds will have Pressure ulcer audits completed bi weekly with new interventions put in place to promote healing per Medical Director or PA.** **Monitoring will be completed daily by Charge Nurses and weekly by Treatment Nurse.**	

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F 314	Continued From page 19 date was noted as 1/5/06. The diagnoses included anemia, hypertension, and diabetes. A review of the minimum data set, dated 11/22/05, revealed that the resident had a stage two pressure sore. A review of the wound assessment record, dated 4/2/06, revealed a stage two pressure sore that measured 0.5 cm by 0.5 cm, to the sacrum. The record, dated 4/24/06, revealed the stage two pressure sore to the sacrum to be 1.0 cm by 0.5 cm. The record revealed new treatment orders, dated 4/23/06, for a left buttocks, denuded stage one pressure sore. Resident #24 was interviewed on 4/26/06 at 12:40 PM. The resident stated that her main concern at the moment was her non healing wound to her sacral area. She stated that she felt that her wound care was being done about once a week. She stated that she spent a lot of time in her wheelchair and had discomfort to her sacral area. She stated that she was concerned about the progress of her wound. She stated that she tried to alleviate the pressure by lying on her side at night. She stated that she was unable to stand up from her wheelchair on her own to alleviate pressure to her wound. The wound care nurse was interviewed on 4/26/06, at 2:05 PM, regarding Resident #24's non healing pressure sore. The nurse stated the resident was encouraged to stay in bed for longer periods of time during the mornings in order to lie on her side. The nurse stated that the resident refused and demanded to be put in her wheelchair. The nurse stated that the wound had healed in the past but came back secondary to the resident's non compliance with repositioning. She also stated that when the resident was repositioned in the wheelchair she would slide	F 314		

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F 314	Continued From page 20 herself back to where she was. The nurse stated that the resident had a top of the line cushion designed to relieve pressure. She also stated that the wound care was being done every three days as ordered. The wound treatment and progress record for Resident #24, dated April 2006, indicated that the wound care was done on 4/4/06. On 4/7/06, saturated (S), is the only thing documented. On 4/9/06, the wound care was documented. On 4/14/06, the wound care was documented. Resident #24 was interviewed again on 4/28/06 at 8:20 AM regarding the frequency of her repositioning. The resident stated that she was not repositioned every two hours throughout the day. When asked if she could stand for brief moments throughout the day she stated that she could with assistance. Resident #24's pressure sore care plan was reviewed. The careplan revealed that the resident was to be repositioned every two hours and as needed. The facility's policy indicated that chair-bound residents were to be repositioned or instructed to reposition themselves every hour or more often as indicated. The director of nursing (DON) was interviewed on 4/28/06 at 8:45 AM regarding resident #24's non healing pressure sore. The DON was asked if any other measures were implemented to help alleviate pressure to the resident's sacral area. She was also asked about the repositioning program and whether the doctor was notified to help resolve the non healing pressure sore. She suggested speaking with the resident's nurse regarding the resident's repositioning program.	F 314		

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F 314	Continued From page 21 Resident #24's nurse was interviewed on 4/28/06 at 9:15 AM regarding the resident's repositioning program. The nurse stated that the resident refused to go back to bed when instructed to do so. The nurse was asked, in those instances, if the resident given the opportunity to stand for a short period of time. The nurse stated that the resident was given the opportunity to stand at times to help alleviate pressure. When the nurse was questioned about the policy regarding repositioning chair bound residents every hour she stated, "oh." She then stated to another nurse sitting at the nurse's station: "She says our policy says every one hour." Resident #24's repositioning schedule was reviewed for April 1 through April 27, 2006. A sample from those dates revealed the following information. On 4/1/06, the resident was on her back for eight hours straight. On 4/2/06, the resident was in a chair for three hours straight during the day shift and for four hours straight during the evening shift. On 4/3/06, the resident was in a chair for six hours straight. On 4/4/06, the resident was in a chair for five hours straight. On 4/5/06, the resident was in a chair for eight hours straight. On 4/6/06, the resident was in a chair for 13 hours straight. On 4/7/6, the resident was in a chair for 10 hours straight. On 4/8/06, the resident was in a chair for four hours straight. On 4/9/06, the resident was on her back for four hours straight. On 4/10/06, the resident was in a chair for four hours straight. On 4/11/06, the resident was in a chair for six hours straight. On 4/13/06, the resident was on her back for four hours straight on the night shift and on her back for five hours straight from the end of the night shift and into the day shift. On 4/14/06, the	F 314		

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F 314	Continued From page 22 resident was on her back for seven hours straight on the night shift, in a chair for eight hours straight on the day shift, and in a chair for five hours straight on the evening shift. On 4/15/06, the resident was on her back for eight hours straight on the night shift and in a chair for six hours straight on the day shift. On 4/16/06, the resident was on her back for eight hours straight on the night shift, for six hours straight in a chair on the day shift, and for four hours straight in a chair on the evening shift. On 4/17/06, the resident was in a chair for five hours straight. There was no evidence found in the record that the resident was repositioned during the above periods. There was no documentation found in the chart noting the reason why the resident was not repositioned during these time periods. On 4/28/06, at 10:45 AM the DON and administrator were shown the above schedule. The DON stated that she would review repositioning with her staff, along with the facility's policy and procedure on repositioning.	F 314		
F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that 1 of 25 residents received necessary services to	F 319		

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F 319	Continued From page 23 treat depression and maintain the highest level of physical and psycho-social functioning. (Resident #11) Findings include: Resident #11: The resident was admitted to the facility on 12/1/03 with diagnoses including acute ill defined cardio-vascular disease, depressive disorder, hypotassemia, abdominal aortic aneurysm, hemiplegia, ischemic heart disease, and protein-calorie malnutrition. The resident had shown symptoms of depression since admission. According to the record the resident refused to leave her room, spent most of the time in bed, refused to participate in any group activities, or dining outside her room. The resident's privacy curtain was pulled around her bed and she remained in her room during the entire survey. According to the medical record the resident received a psychiatric evaluation on 12/24/03. At that time the resident was placed on Remeron for depression. The resident took the medication for 13 months and then refused to take the medication any longer, stating that she "did not like the way it makes me feel." There was no documentation that any additional psychiatric consultations were done even though the resident has continued to self-isolate, have angry outbursts, and refuse medications and meals.	F 319	**F 319** **All residents have the potential to be affected by this deficient practice.** **A Geriatric Depression Scale has been completed for resident # 11. A psychiatric consultation has been ordered for resident # 11.** **An audit of all residents with a diagnosis of depression will be initiated by the DON/ADON. A review of appropriate psychiatric consultations will be audited as well as recent interventions related to depressive behaviors.** **Monitoring will occur during Pharmacy Consultant meeting, in Standards of Care weekly meeting and by the Quality Assurance Committee.**	6-8-06
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of	F 325		

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F 325	Continued From page 24 nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that 1 of 25 residents received necessary services to maintain acceptable weight parameters. (Resident #11) Findings include: Resident #11: The resident was admitted to the facility on 12/1/03 with diagnoses including acute ill defined cardio-vascular disease, depressive disorder, hypotassemia, abdominal aortic aneurysm, hemiplegia, ischemic heart disease, and protein-calorie malnutrition. The resident entered the facility weighing 107 pounds. The ideal body weight was listed at 115 to 121 pounds. The resident had experienced a steady weight loss over the last 180 days. The resident's weight on 4/1/06 was 101 pounds and on 4/25/06 was 93 pounds. According to the meal record for March 2006 the resident refused twelve meals during the month. According to dietary progress notes the resident's average percentage intake was 15-25% at breakfast, 38% at lunch, and 40% at dinner with refusals less than 50%. The last dietary progress note indicated that there were no recent laboratory values on the resident. According to the record the resident refused the last blood draw order for laboratory tests.	F 325	**F 325** **All residents have the potential to be affected by this deficient practice.** **Resident # 11 has been placed on weekly weights. A nutritional evaluation by Registered Dietician was completed. A Geriatric Depression scale and psychiatric consult has been initiated. Speech screen for swallowing evaluation ordered and Lab values ordered by Physician Assistant.** **Weekly weight meetings will continue with review of all weight fluctuations and appropriate interventions will be implemented.** **Monitoring will occur in weekly weight meetings, Standard of Care meetings and on an on going basis.** RECEIVED MAY 19 2006 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	6-8-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/28/2006

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F 325	Continued From page 25 The facility failed to pursue aggressive action to ensure the resident maintained acceptable weight parameters.	F 325		
F 441 SS=B	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility failed to provide documentation of the reasons for refusal of immunizations on 5 of 25 residents. Findings include: With this review it was noted that reasons why immunizations of pneumococcal vaccination and the influenza vaccination were being refused by residents was not documented in 5 of 25 resident records. (Resident #1, #7, #8, #9, #15)	F 441	**F 441** **All residents have the potential to be affected by this deficient practice.** **Proper documentation on reasons why residents #1, #7, #8, #9 and #15 refused pneumococcal immunizations has been documented and proper CDC immunization information sheets have been given to and explained to these residents.** **The Infection Control Nurse will in service licensed staff on proper patient education for flu and pneumonia immunizations. CDC immunization information sheets will be provided and explained to all residents. Documentation for reason of refusal will be implemented.** **Monitoring will take place in Standards of Care Meetings weekly.**	6-8-06
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which	F 444		

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F 444	Continued From page 26 handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation of wound care, facility policies, and interview it was determined that the facility failed to ensure that standard practices infection control were followed in regard to hand washing during wound care observations for 3 of 5 residents. (Residents #23, #20, and #7) Findings include: Review of the use of the facility's monitoring tool identified as the Infection Control Environmental Surveillance form revealed that the facility monitored nursing and non-nursing departments for proper infection control. The checklist identified as "Pressure ulcers" section "Handwashing" was used to observe staff handwashing before setting up a clean field of dressing supplies and then at the end of the dressing change before leaving the resident's room. Review of the facility's policy for Handwashing revealed a statement that "Handwashing is the most important component for preventing the spread of infection." The policy also included when handwashing should be done and listed specific instances, identified as A-M. The last instance read "After removal of medical/surgical or utility gloves." Standards of infection control cited by the facility policies were the APIC (Association of Professional Infection Control and Epidemiology) guideline for handwashing and hand antisepsis in	F 444	**F444** **All residents have the potential to be affected by this deficient practice.** **Resident # 23 and # 20 have been discharged from the facility.** **Resident # 7 wound care modification has been made to include handwashing between glove changes during wound care.** **In services for all licensed staff will be completed by the Infection Control Nurse to include infection control surveillance competency validation for wound care, Standards of Practice indications for glove use and Standard of Practice for handwashing.** **Tracking and trending will continue to be monitored by the Infection Control Team for cross contamination on an on going basis.** RECEIVED MAY 19 2006 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	6-8-06

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F 444	Continued From page 27 health care settings and Surveillance, Prevention and Control of Infections Standards of Practice. During course of the survey five wound care observations were observed. The following observations were made during three of the observations: Resident #23: The resident had two wounds on his left leg. An observation of wound care revealed that the nurse changed her gloves in excess of four times during the procedure. She changed her gloves between removing the soiled dressings and applying clean dressings (dirty and clean steps). The wound care nurse also changed gloves after finishing the wound care on one wound before starting on the other wound. The wound care nurse was observed to have washed her hands only at the beginning and end of the entire wound care procedure not between glove changes as indicated in the policy. Resident #20: The resident had four wounds on his left foot and leg and a rash on his buttocks and rectal area. The wound care nurse changed gloves in excess of six times between the dirty and clean steps. The wound care nurse also had brought in a squeeze bottle of waterless hand cleaner which was placed on the area being used as a dressing field. The wound care nurse washed her hands only at the beginning and end of the entire wound care procedure. The wound care nurse did not use the waterless hand cleaner. The wound care nurse was assisted by a CNA during the wound care. The CNA was observed to wash her hands between each glove change and had changed gloves in excess of two times	F 444		

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F 444	Continued From page 28 during two of the three wound care procedures. The observation of handwashing technique (between glove changes) by the CNA was brought to the attention of the wound care nurse. The wound care nurse revealed that the CNAs have had multiple inservices and instruction on handwashing by the wound care nurse. The observation of the absence of handwashing between glove changes by the nurse was brought to the attention of wound care nurse. Resident #7: During an observation of wound care by the wound care nurse on the morning of 04/25/06, it was noted that the wound care nurse did not wash her hands between glove changes. She also failed to change gloves between cleansing the wound, the application of an ointment, packing and dressing the wound.	F 444		